Reissued

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To:	Maternity Support Services (MSS)/Infant Case Management (ICM) Providers CSO First Steps Social Workers Managed Care Organizations	**Memorandum No: 07-21** **Re-Issued:** June 13, 2007 **For information contact** 800.562.3022 or go to: http://maa.dshs.wa.gov/contact/prucontact.asp
From:	Douglas Porter, Assistant Secretary Health and Recovery Services Administration (HRSA)	**Supersedes # Memorandum:** 06-49
Subject:	**Maternity Support Services/Infant Case Management: Updating and Clarifying Policy and Billing Instructions**	

Effective on and after September 1, 2007, the Health and Recovery Services Administration (HRSA) is updating and clarifying policy and billing instructions for the Maternity Support Services (MSS) and Infant Case Management (ICM) programs.

MSS:

- Update Place of Service (POS) codes;
- Billing clarification if two or more MSS/ICM providers visit a client together;
- Student interns cannot bill for services [Refer to WAC 388-533-0325];
- Registered Dietitian (RD) certification [Refer to WAC 388-533-0325];
- Policy change in minimum number of units;
- Update coverage table; and
- Community Health Worker procedure code.

Both MSS and ICM:

- Clarification on how to bill units per visit;
- Update POS codes; and
- Documentation requirement for client visit start and end times.

This memo is reissued to remove the Maximum Allowable Fee sections that were included in the previously issued memo. They were included in error.

MSS Place of Service (POS) Update

The provider, in collaboration with the client, determines whether the services are to be delivered in the home or in the agency's office or clinic.

Retroactive to dates of service on and after February 5, 2007, tribal health facilities may also use the POS codes 07 and 08 to bill fee-for-service MSS visits.

POS Code	Use for
07	Tribal 638 free standing facility
08	Tribal 638 provider based facility
11	Office (Agency's office or clinic)
12	Home (Client's place of residence)

Maternity Support Services (MSS)

MSS Units of Service Billing Limitations

Community health nursing visits, registered dietitian visits, behavioral health visits, and community health worker visits are subject to the following ***limitations*** per client**.**

- One unit of service equals 15 minutes. Providers must bill in units. See **Minimum and Maximum Number of Units** on next page.

Minutes	Units
0-14 minutes	= 0 units
15 minutes	= 1 unit
16-29 minutes	= 1 unit
30 minutes	= 2 units

Billing for MSS

When billing for MSS, the MSS/ICM provider must meet the following requirements:

- Only the time spent providing MSS services is billable. The time the client's visit **begins** and **ends** must be recorded and documented in the client's chart.
- The Tobacco Cessation and Family Planning Performance Measures may be billed only once per client, per pregnancy (bill post pregnancy).
- If two or more MSS providers meet with a client at the same time, only 1 discipline can bill for each 15 minute unit. For example, if a registered nurse and registered dietitian visit a client at the same time for 45 minutes, a maximum of 3 units is billable for this visit (not 6 units).

Note: HRSA does not pay for any First Steps services provided by student interns (nursing, behavioral health or dietitian)

- When billing for First Steps nutrition services, the MSS/ICM provider must meet the following requirements:
    - Currently registered with the Commission on Dietetic Registration.
    - Washington State Certified Dietitian
        - ✓ Registered Dietitians (RDs) who began working in MSS after January 25, 2007 are required to be a Washington State certified dietitian by July 1, 2007.
        - ✓ All RDs working in MSS prior to January 25, 2007 are required to be a Washington State certified dietitian by March 1, 2008.

Minimum and Maximum Numbers of Units

HRSA allows:

- A minimum of 1 unit**,** per client, per visit;
- A maximum of six units, per client, per day for any combination of visits; and
- A maximum of 60 units (which includes services provided by all disciplines), per client for visits over the maternity cycle. (The **maternity cycle** is the period of time during pregnancy and 60 days postpregnancy. If the 60th day postpregnancy occurs before the last day of the month, then the maternity cycle extends to the last day of that same month. Otherwise, if the 60th day postpregnancy occurs on the last day of the month, then the maternity cycle ends that day.)

Covered Codes Service Description

Effective September 1, 2007, procedure code T1019 will be deleted and replaced with procedure code T1027 for the Community Health Worker. See table below.

Use diagnosis code V22.2 when billing for the following procedure codes:

Procedure Code	Modifier	Diagnosis Code	Brief Description	Policy/Comments
S9470	HD	V22.2	Nutritional counseling, diet	Registered Dietitian visit **1 unit = 15 minutes**
96152	HD	V22.2	Intervene hlth/behave, indiv	Behavioral Health visit **1 unit = 15 minutes**
T1027	HD	V22.2	Family training and counseling for child development (Community Health Worker)	Community Health Worker visit **1 unit = 15 minutes**

Infant Case Management (ICM)

Billing Limitations for ICM Units of Service

- One unit of service equals 15 minutes. Providers must bill in units.

Minutes	Units
0-14 minutes	= 0 units
15 minutes	= 1 unit
16-29 minutes	= 1 unit
30 minutes	= 2 units

ICM Place of Service Update

HRSA pays for an ICM visit when services are provided in:

- Agency's office or clinic;
- The infant's (client's) home; or
- In the case of an unsafe place of residence or a potential problem with client confidentiality, an alternate site other than a home may be used.

Retroactive to dates of service on and after February 5, 2007, tribal health facilities may also use the following POS codes to bill fee-for-service ICM visits.

POS Code	Use for
07	Tribal 638 free standing facility
08	Tribal 638 provider based facility
11	Office (Agency's office or clinic)
12	Home (Client's place of residence)

Billing for ICM

- Only the time spent providing ICM services is billable. The time the client's visit **begins** and **ends** must be recorded and documented in the client's chart.
- ICM providers must have individual, face-to-face contact with the client (infant) and parent in order to bill for ICM.

Minimum and Maximum Numbers of Units

HRSA allows:

- A minimum of 1 unit**,** per client, per visit;
- A maximum of 6 units, per client, per month for any combination of office and/or home visits; and
- A maximum of 40 units, per client, during the 10 months following the maternity cycle.

Billing Instructions Replacement Pages

Attached are updated replacement pages B.1 – B.10, C.1 – C. 6, and E.1 - E.2 for HRSA's current *Maternity Support Services (MSS)/Infant Case Management (ICM) Billing Instructions.*

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing the WAMedWeb at http://wamedweb.acs-inc.com.

How can I get HRSA's provider documents?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Maternity Support Services

What are Maternity Support Services?

Maternity Support Services are provided by members of the agency's interdisciplinary team: Community Health Nurse (CHN), Registered Dietitian (RD), Behavioral Health Specialist (BHS), and a Community Health Worker (CHW) (acting under the direction of a professional on the Interdisciplinary team). Refer to the First Steps Manual for detailed information regarding staffing qualifications.

The primary focus of Maternity Support Services is risk assessment, interventions, linkages and referrals. Professional interventions are based on risk factors that are known to impact pregnancy and parenting outcomes (including the Family Planning Performance Measure and the Tobacco Cessation During Pregnancy Performance Measure).

What are the provider requirements for MSS/ICM?

Services must be provided only by HRSA approved MSS/ICM providers. Representatives from DSHS HRSA and the Department of Health (DOH) recruit and approve providers using the following criteria:

- Services must be delivered in an area of geographic need as determined by DSHS/DOH program guidelines;
- Providers must:
  - ✓ Deliver both MSS and ICM services;
  - ✓ Provide services in both office and home visit settings; and
  - ✓ Assure program staffing requirements and delivery of services meet program policies.

HRSA considers services provided and billed by staff not qualified to provide those services as erroneous billings and will recoup any resulting overpayment.

- MSS/ICM providers must also:
  - ✓ Refer a client who may need chemical dependency assessment to a provider who is contracted with the Division of Alcohol and Substance Abuse (DASA); and
  - ✓ Screen for the eligible woman's need for childcare, discuss and encourage a safe/ healthy childcare plan, and if needed, initiate the process for First Steps Childcare services (See page A.3).

What are the provider requirements for MSS/ICM? (Continued)

To be reimbursed by HRSA for MSS, a MSS/ICM provider must:

- Meet the requirements in chapter 388-502 WAC Administration of Medical Programs - Provider rules;
- Have a completed, approved MSS/ICM Assurances document, signed by an officer or employee qualified to sign on behalf of the provider, on file with HRSA;
- Meet the HRSA/DOH requirements for a qualified MSS interdisciplinary team as described in the Assurance document;
- Ensure that the staff meet the minimum qualifications for the MSS roles they perform;
- Comply with the clinical supervision/clinical consultation guidelines as required in the Assurances document;
- Notify the appropriate state discipline-specific consultant when a staff person joins or leaves a designated position;
- Ensure that all newly hired staff receive a First Steps Orientation as soon as possible, but not later than 60 days from the hire date;
- Conduct case conferencing activities as specified in the provider requirements; and
- Submit claims as directed in these billing instructions.

Note: HRSA will not pay for any First Steps services provided by student interns (nursing, behavioral health or dietitian).

When billing for First Steps nutrition services, program staff must meet the following requirements.

- Currently registered with the Commission on Dietetic Registration.
- Washington State Certified Dietitian
  - Registered Dietitians (RDs) who began working in MSS on and after January 25, 2007 are required to be a Washington State certified dietitian by July 1, 2007.
  - All RDs working in MSS prior to January 25, 2007 are required to be a Washington State certified dietitian by March 1, 2008.

Who is eligible for MSS?

To be eligible for MSS, a client must:

- Be pregnant or within 60 days postpregnancy; and
- Present a DSHS Medical ID card with one of the following identifiers:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP Children's Health	Categorically Needy Program - Children's Health
CNP – CHIP	Categorically Needy Program - Children's Health Insurance Program
CNP-Emergency Medical Only	Categorically Needy Program- Emergency Medical Only

Note: If the client is pregnant but her card does not list one of the above medical program identifiers, please refer her to the local Community Services Office (CSO) to be evaluated for a possible change in her medical assistance program that would enable her to receive full scope maternity care.

Are clients enrolled in an HRSA managed care plan eligible for MSS?

Yes! Clients who are enrolled in an HRSA managed care plan are eligible for MSS outside their plan. HRSA reimburses for MSS/ICM through its fee-for-service system. Coverage and billing guidelines found in these billing instructions apply to managed care clients. **Bill HRSA directly.** Clients who are enrolled in an HRSA managed care plan will have an "HMO" identifier in the HMO column on their DSHS Medical ID cards.

How long is a woman eligible for MSS?

Medicaid eligible women may receive MSS during pregnancy and through the postpregnancy period (the last day of the month from the 60th day after the pregnancy ends). Services will be offered during the maternity cycle as long as there is a need for identified core services and minimum interventions.

What is covered for MSS?

HRSA covers the following for MSS:

- Community Health Nurse visits;
- Registered Dietitian visits;
- Behavioral Health Specialist visits; and
- Community Health Worker visits.

HRSA will reimburse MSS/ICM providers on a fee-for-service basis for the above services only when the services are:

- Documented in the client's chart;
- Provided in a face-to-face encounter;
- Delivered by a qualified staff person acting within their area of expertise; and
- Only when used for the purposes of the MSS program to:

  - ✓ Provide risk screening (see page B.6);
  - ✓ Deliver basic health messages;
  - ✓ Provide interventions based on identified risk factors;
  - ✓ Provide referral and linkages to other services;
  - ✓ Provide family planning screening; or
  - ✓ Provide tobacco cessation during pregnancy performance measure requirements.

Place of Service Codes (POS) for MSS services

The provider, in collaboration with the client, determines whether the services are delivered in the home or in the agency's office or clinic.

Retroactive to dates of service on and after February 5, 2007, tribal health facilities may also use the POS codes 07 and 08 to bill fee-for-service MSS visits.

Place of Service Code	Use for
07	Tribal 638 free standing facility
08	Tribal 638 provider based facility
11	Office (Agency's office or clinic)
12	Home (Client's place of residence)

MSS Performance Measures

Unintended Pregnancy Family Planning Performance Measure

All MSS/ICM agencies are required to complete the MSS Family Planning Performance Measure with each client. MSS providers must include in their interventions family planning education so that each woman can decide if and when to use birth control and which method would work the best for her. The completion of the performance measure documentation must be completed in the postpregnancy period.

MSS providers must bill the family planning performance measure procedure only once per client, per pregnancy and are to bill post pregnancy.

Tobacco Cessation During Pregnancy Performance Measure

All MSS/ICM agencies are required to complete the MSS Tobacco Cessation during Pregnancy Performance Measure with each client.

MSS providers must include ongoing assessment and education regarding tobacco cessation and second hand smoke exposure reduction. Documentation must ensure that the client is asked about tobacco usage and/or exposure to secondhand smoke, and is offered an appropriate and individualized intervention; and

MSS Providers must bill the tobacco cessation performance measure procedure, only once per client, per pregnancy, in the postpregnancy period.

Maternity Support Services Client Screening Tool

MSS qualified staff must provide risk screening using one or more forms listed below:

- Prenatal New Client;
- Postpartum New Client;
- Postpartum Returning Client; and
- Infant Initial Screening

Completed screening tools must be kept in the client's chart. You may download the forms at http://maa.dshs.wa.gov/firststeps/Provider%20Page/First%20Steps%20Documentation/Documentation.index.htm.

Billing for MSS

- Bill HRSA using the client's Patient Identification Code (PIC) found on the DSHS Medical ID Card.

- Only the time spent providing MSS services is billable. The time the client's visit **begins** and **ends** must be recorded and documented in the client's chart.

- An initial face-to-face visit may be billed to HRSA without a signed consent form if the client refuses further services, as long as this refusal is documented in the chart. Only bill for services provided to the pregnant/post pregnant woman.

- Travel expenses, charting time/documentation, phone calls and mileage have been factored into the reimbursement rate for MSS.

- If the client becomes pregnant again within 12 months from the previous pregnancy, enter the new "Due Date" in field 19 on the 1500 Claim Form for new MSS services. This "resets" the claims processing clock for the new pregnancy.

Minimum and Maximum Number of Visits

- Community health nursing visits, dietitian visits, behavioral visits, and community health worker visits are subject to the following limitations per client:

  - One unit of service equals 15 minutes. Providers must bill in units.

    - If two or more MSS providers meet with a client at the same time, only 1 discipline can bill for each 15 minute unit. For example, if a registered nurse and registered dietitian visit a client together for 45 minutes, a maximum of three units is billable for this visit (not 6 units).

    - ✓ A minimum of 1 unit must be provided per day when billing for a visit;
    - ✓ A maximum of 6 units may be billed per day for any combination of office and/or home visits; and
    - ✓ A maximum of 60 units from all disciplines combined may be billed for office and/or home visits over the maternity cycle (pregnancy through two months postpregnancy).

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Note: HRSA will not pay for any First Steps services provided by student interns (nursing, behavioral health or dietitian).

MSS/ICM Services Coverage Table

Procedure Code	Diagnosis Code	Modifier	Brief Description	Policy/ Comments
Maternity Support Services				
T1002	V22.2	HD	RN services, up to 15 minutes	**1 unit = 15 minutes** during a MSS Community Health Nursing Visit
S9470	V22.2	HD	Nutritional Counseling, dietitian visit	**1 unit = 15 minutes** during a MSS Dietitian Visit
96152	V22.2	HD	Behavioral Health Specialist	**1 unit = 15 minutes during a** MSS Behavioral Health Visit
T1019	V22.2	HD	Personal care services (Community Health Worker)	**1 unit = 15 minutes** **Use for dates of service *prior* to 9/1/2007.**
T1027	V22.2	HD	Family training and counseling for child development (Community Health Worker)	**1 unit = 15 minutes** during a MSS Community Health Worker Visit **Use for dates of service 9/1/2007 or after.**
Family Planning Performance Measure				
T1023	V22.2	HD	Program intake assessment	Family Planning Performance Measure may be billed **only once per client, per pregnancy** (bill postpregnancy).
Tobacco Cessation During Pregnancy Performance Measure				
S9075	V22.2	HD	Smoking Cessation Education	MSS Tobacco Cessation Performance Measure may be billed **only once per client, per pregnancy** (bill postpregnancy).
Infant Case Management				
T1017	V20.1	HD	Targeted Case Management	**1 unit = 15 minutes during a ICM visit**

Billing Reminder: Travel expenses, charting time/documentation, phone calls and mileage are factored into the reimbursement rate for MSS/ICM.

Fee Schedule

You may view HRSA's **Maternity Support Services/Infant Case Management Fee Schedule** on-line at:

http://maa.dshs.wa.gov/RBRVS/Index.html

For a paper copy of the fee schedule:

- **Go to:** http://www.prt.wa.gov/ (On-line orders filled daily.) Click **General Store**. Follow prompts to **Store Lobby → Search by Agency → Department of Social and Health Services → Health and Recovery Services Administration →** desired document; **or**

- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/ telephone 360.586.6360. (Faxed or telephoned orders may take up to 2 weeks to fill.)

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Infant Case Management

What is Infant Case Management (ICM)?

The Infant Case Management (ICM) program is the part of MSS/ICM services for high-risk infants and their families. The goal of ICM is to improve the parent(s) self-sufficiency in gaining access to needed medical, social, educational, and other services (SSA 1915[g]).

At the end of the maternity cycle, MSS staff assess family needs as they relate to the infant. Families meeting the criteria for Infant Case Management (ICM) will be offered services that focus on referrals, linkages and client advocacy. Families who did not receive MSS may be eligible for ICM services.

What are the provider requirements for ICM?

Services under this program are provided only by HRSA approved MSS/ICM providers. Representatives from the DSHS HRSA and DOH the recruit and approve MSS/ICM providers using the following criteria:

- Services must be delivered in an area of geographic need as determined by DSHS/DOH program guidelines;

- Providers must:

  ✓ Deliver both MSS and ICM services;
  ✓ Provide services in both office and home visit settings; and
  ✓ Assure program staffing requirements and delivery of services meet program policies.

HRSA considers services provided and billed by staff not qualified to provide those services as erroneous billings and will recoup any resulting overpayment.

To be reimbursed by HRSA for MSS/ICM, a provider must:

- Meet the requirements in chapter 388-502 WAC, Administration of Medical Programs – Providers rules;
- Have a completed, approved MSS/ICM Assurances document, signed by an officer or employee qualified to sign on behalf of the provider, on file with HRSA;
- Ensure the MSS/ICM provider meet the minimum qualifications for the ICM roles they perform;
- Comply with the clinical supervision/clinical consultation guidelines as required in the Assurances document;
- Notify the appropriate state discipline-specific consultant when a staff person joins or leaves a designated position;
- Ensure that all newly hired staff receive an orientation to First Steps as soon as possible, but not later than 60 days from the hire date; and
- Submit billings as described in these instructions.

Who is eligible for ICM?

To be eligible for ICM, the parent/infant must:

- Present the infant's DSHS Medical ID card with one of the following identifiers:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP Children's Health	Categorically Needy Program - Children's Health
CNP – CHIP	Categorically Needy Program - Children's Health Insurance Program
CNP-Emergency Medical Only	Categorically Needy Program- Emergency Medical Only

- Need assistance in accessing/providing care for themselves or their family; and
- Meet at least one of the criteria listed on the ICM Intake form [DSHS 13-658]. To downloadable the form, go to http://www1.dshs.wa.gov/msa/forms/eforms.html.

Are clients enrolled in an HRSA managed care plan eligible for ICM?

Yes! Clients who are enrolled in an HRSA managed care plan are eligible for ICM outside their plan. HRSA reimburses for MSS/ICM through its fee-for-service system. Coverage and billing guidelines found in these billing instructions apply to managed care clients. **Bill HRSA directly.** Clients who are enrolled in an HRSA managed care plan will have an "HMO" identifier in the HMO column on their DSHS Medical ID cards.

How long is a client eligible for ICM?

Services may continue until the end of the month in which the infant's first birthday occurs. This applies to eligible families who demonstrate a need for assistance in accessing/providing care for the parent(s) and infant and there is an active plan for care.

What if the woman becomes pregnant while receiving ICM?

If a woman becomes pregnant again while receiving ICM, ICM services are closed. Begin Maternity Support Services for the new pregnancy and bill using MSS procedure codes. See page E.1, field 19 for 1500 Claim Form instructions.

Can ICM continue if the infant is placed outside the home?

If the infant does not live with either biological parent, the provider must terminate or deactivate services. If the infant is returned to either biological parent before his/her first birthday, the provider may reassess for ICM eligibility.

Example A:

> A child is placed outside the home in foster care, Children's Administration (CA) provides Targeted Case Management (TCM) and is the legal custodian of the child. This child is no longer eligible for ICM.

Example B:

For a CPS child who is still in their biological parents' home and no other Title XIX case management is being provided (like Early Intervention Program (EIP) services) then ICM could be delivered to the family in the home without the concern of duplicate billing.

If more than one Title XIX funded service is involved with an ICM family, then HRSA would duplicate services. ICM would be closed in order to prevent duplicate payments.

Example C:

Grandparents have legal custody of the infant. Is this billable to ICM? No, the infant must be living with a biological parent.

What services are covered under ICM?

HRSA reimburses approved MSS/ICM providers on a fee-for-service basis for case management under the ICM program including:

- Assessing risk and need;
- Reviewing and updating the infant and parent(s) plan for care;
- Referring and linking the client to other agencies; and
- Advocating for the client with other agencies.

The case management activities listed above are covered under the ICM program only when:

- Documented in the client's record;
- Performed by a qualified staff person acting within his or her area of expertise; and
- Performed according to program design as described in the MSS/ICM Assurances.

Billing for ICM

- Only the time spent providing ICM services is billable. The time the client's visit **begins** and **ends** must be recorded and documented in the client's chart.

- Bill HRSA for ICM services using the baby's PIC as listed on the baby's DSHS Medical ID card. Do not use the mother's PIC.

- ICM is considered family-based intervention. Therefore, the infant [and family] are only allowed one Title XIX Targeted Case Manager.

Billing for ICM (Continued)

- Travel expenses, charting time/documentation, phone calls and mileage have been factored into the reimbursement rate for ICM.

- ICM is provided for parent/infant meeting eligibility criteria. (Services can be provided from the end of the maternity cycle to the infant's first birthday.) The following limitations per client apply:

- **One unit of service equals 15 minutes. Providers must bill in units.**

Place of Service Codes for ICM services

HRSA pays for an ICM visit when the services are provided in:

- **An agency's office or clinic; or**
- **The infant's home (client's residence); or**
- **In the case of an unsafe place of residence or a potential problem with client confidentiality, an alternate site not the client's residence may be used.**

Retroactive to dates of service on and after February 5, 2007, tribal health facilities may also use the following POS codes to bill fee-for-service ICM visits.

Place of Service Code	Use for
07	Tribal 638 free standing facility
08	Tribal 638 provider based facility
11	Office (Agency's office or clinic)
12	Home (Client's place of residence)

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Completing the 1500 Claim Form

Attention!

- **On November 1, 2006, HRSA now accepts the new 1500 Claim Form (version 08/05).**
- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 claim form.

Note: HRSA encourages providers to make use of electronic billing options.
For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 Claim Form. You may download this booklet from HRSA's website at: http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html or request a paper copy from the Department of Printing (see Important Contacts section).

The following 1500 claim form instructions relate to **MSS/ICM Billing Instructions**. Click the link above to view general 1500 Claim Form instructions.

For questions regarding claims information, call HRSA toll-free:

800.562.3022

1500 Claim Form Field Descriptions

Field No.	Name	Field Required	Entry
19.	**Reserved for Local Use**		Enter the estimated due date for clients who become pregnant again before ICM ends. This is necessary in order to "Reset" the clock for the new pregnancy in the claims system.
22.	**Medicaid Resubmission**	When applicable.	If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) **Print in field 19 "SEE BOX 22."**

Field No.	Name	Field Required	Entry
24B.	**Place of Service**	Yes	These are the only appropriate code(s) for this billing instruction: **Code Number** **To Be Used For** 07 Tribal 638 free standing facility 08 Tribal 638 provider based facility 11 Office 12 Client's residence (home visit)
24G.	**Days or Units**	Yes	One date of service per billed line. Multiple units will be billed regularly using the 15-minute codes.